		FOR OHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

I. IDPH Facility ID Number: 0034736

Facility Name: ARBOUR HEALTH CARE CENTER

Address: 1512 W. FARGO (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 465-7751 **Fax #** (773) 338-2286

IDPA ID Number: 36-3614638

Date of Initial License for Current Owners: 12/1/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,620	1
2		Skilled Pediatric (SNF/PED)			2
3	29	Intermediate (ICF)	29	10,614	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	683			683	8
9	SNF/PED					9
10	ICF	29,074	1,397		30,471	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,757	1,397		31,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.98%

D. How many bed-hold days during this year were paid by Public Aid?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,708	23,710	5,931	150,349		150,349		150,349			1
2	Food Purchase		122,695		122,695	(26,132)	96,563	(55)	96,508			2
3	Housekeeping	87,454	26,059		113,513		113,513		113,513			3
4	Laundry	37,383	8,121		45,504		45,504		45,504			4
5	Heat and Other Utilities			55,490	55,490		55,490	1,431	56,921			5
6	Maintenance	26,643	16,486	52,476	95,605		95,605	(12,888)	82,717			6
7	Other (specify):*							1,058	1,058			7
8	**TOTAL General Services**	272,188	197,071	113,897	583,156	(26,132)	557,024	(10,454)	546,570			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	916,920	15,039	5,460	937,419		937,419	(639)	936,780			10
10a	Therapy	40,297		14,726	55,023		55,023		55,023			10a
11	Activities	59,446	2,888	3,090	65,424		65,424		65,424			11
12	Social Services	59,142		5,602	64,744		64,744		64,744			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,075,805	17,927	30,678	1,124,410		1,124,410	(639)	1,123,771			16
	C. General Administration											
17	Administrative	122,327		173,000	295,327		295,327	(76,175)	219,152			17
18	Directors Fees											18
19	Professional Services			15,719	15,719		15,719	804	16,523			19
20	Dues, Fees, Subscriptions & Promotions			24,115	24,115		24,115	(2,380)	21,735			20
21	Clerical & General Office Expenses	39,770	28,585	12,048	80,403		80,403	20,276	100,679			21
22	Employee Benefits & Payroll Taxes			194,087	194,087	26,132	220,219		220,219			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,058	2,058		2,058	294	2,352			24
25	Other Admin. Staff Transportation			161	161		161	1,448	1,609			25
26	Insurance-Prop.Liab.Malpractice			29,499	29,499		29,499	1,389	30,888			26
27	Other (specify):*							8,345	8,345			27
28	**TOTAL General Administration**	162,097	28,585	450,687	641,369	26,132	667,501	(45,999)	621,502			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,510,090	243,583	595,262	2,348,935		2,348,935	(57,092)	2,291,843			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ARBOUR HEALTH CARE CENTER
0034736
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	26,132	
2	FOOD		26,132

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number ARBOUR HEALTH CARE CENTER #0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			3,600	3,600		3,600	135,945	139,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							165,873	165,873			32
33	Real Estate Taxes			118,601	118,601		118,601		118,601			33
34	Rent-Facility & Grounds			282,201	282,201		282,201	(274,655)	7,546			34
35	Rent-Equipment & Vehicles			2,234	2,234		2,234	3,537	5,771			35
36	Other (specify):*											36
37	**TOTAL Ownership**			406,636	406,636		406,636	30,700	437,336			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			54,352	54,352		54,352		54,352			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,510,090	243,583	1,056,250	2,809,923		2,809,923	(26,392)	2,783,531			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	60,712	30		9
10	Interest and Other Investment Income	(8,715)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(180)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,752)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,974)	20		28
29	Other-Attach Schedule	(19,443)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ 26,593		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(52,985)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (52,985)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (26,392)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

ARBOUR HEALTH CARE CENTER

ID# 0034736

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Contributions	(300)	20	2
3	Legal Fees - Out of Period	(233)	19	3
4	Capitalized Repair & Maintenance	(18,721)	6	4
5	Political Contributions - Illinois Council	(189)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(19,443)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(55)											(55)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,431									1,431	5
6	Maintenance	(18,721)		571	5,262								(12,888)	6
7	Other (specify):*				1,058								1,058	7
8	**TOTAL General Services**	(18,776)		2,002	6,320								(10,454)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(639)									(639)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			(639)									(639)	16
	C. General Administration													
17	Administrative			14,573	(90,748)								(76,175)	17
18	Directors Fees													18
19	Professional Services	(233)		1,037									804	19
20	Fees, Subscriptions & Promotions	(2,643)		263									(2,380)	20
21	Clerical & General Office Expenses	(3,752)		24,028									20,276	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			294									294	24
25	Other Admin. Staff Transportation			1,448									1,448	25
26	Insurance-Prop.Liab.Malpractice			1,389									1,389	26
27	Other (specify):*			4,313	4,032								8,345	27
28	**TOTAL General Administration**	(6,628)		47,345	(86,716)								(45,999)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,404)		48,708	(80,396)								(57,092)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	60,712	73,254	1,979									135,945	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,715)	174,588										165,873	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(282,201)	7,546									(274,655)	34
35	Rent-Equipment & Vehicles			3,537									3,537	35
36	Other (specify):*													36
37	**TOTAL Ownership**	51,997	(34,359)	13,062									30,700	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	26,593	(34,359)	61,770	(80,396)								(26,392)	45

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See Attached		
				Arbour HHC		
				Limited Partnership	Chicago	Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Mortgage Interest	$	Arbour HCC Limited Partnership		$ 174,588	$ 174,588	1
2	V	30	Depreciation		Arbour HCC Limited Partnership		73,254	73,254	2
3	V	34	Rent Income	282,201	Arbour HCC Limited Partnership			(282,201)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 282,201			$ 247,842	$ * (34,359)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 1,431	$ 1,431	15
16	V	6	REPAIRS AND MAINT.		STAY CARE MANAGEMENT, LTD.	100.00%	571	571	16
17	V	10	REHABILITATION CONS.		STAY CARE MANAGEMENT, LTD.	100.00%	(639)	(639)	17
18	V	17	ADMIN. SAL.-NON OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	14,573	14,573	18
19	V	19	PROFESSIONAL FEES		STAY CARE MANAGEMENT, LTD.	100.00%	1,037	1,037	19
20	V	20	DUES, SUBSCRIPTIONS		STAY CARE MANAGEMENT, LTD.	100.00%	263	263	20
21	V	21	CLERICAL & GENERAL		STAY CARE MANAGEMENT, LTD.	100.00%	24,028	24,028	21
22	V	24	SEMINARS		STAY CARE MANAGEMENT, LTD.	100.00%	294	294	22
23	V	25	ADMIN. STAFF TRAVEL		STAY CARE MANAGEMENT, LTD.	100.00%	1,448	1,448	23
24	V	26	INSURANCE		STAY CARE MANAGEMENT, LTD.	100.00%	1,389	1,389	24
25	V	27	EMPLOYEE BENEFITS		STAY CARE MANAGEMENT, LTD.	100.00%	4,313	4,313	25
26	V	30	DEPRECIATION		STAY CARE MANAGEMENT, LTD.	100.00%	1,979	1,979	26
27	V	34	BUILDING RENT		STAY CARE MANAGEMENT, LTD.	100.00%	7,546	7,546	27
28	V	35	EQUIPMENT RENTAL		STAY CARE MANAGEMENT, LTD.	100.00%	3,537	3,537	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 61,770	$ * 61,770	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 0	$	15
16	V	6	MAINT. COMP. - NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	5,262	5,262	16
17	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	0		17
18	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	1,058	1,058	18
19	V	17	ADMIN. BONUS		STAY CARE MANAGEMENT, LTD.	100.00%	0		19
20	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	21,355	21,355	20
21	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	60,897	60,897	21
22	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	1,020	1,020	22
23	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	3,012	3,012	23
24	V	30	DEPR.- AUTO - MINI VAN		STAY CARE MANAGEMENT, LTD.	100.00%	0		24
25	V	17	MANAGEMENT FEES	173,000	STAY CARE MANAGEMENT, LTD.	100.00%	0	(173,000)	25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 173,000			$ 92,604	$ * (80,396)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administrative	29.12%	See Attached	15	23.07%	Admin. Salary	$ 60,897	17-7	1
2	Howard Wengrow	Owner	Administrative	26.09%	See Attached	5	7.69%	Admin. Salary	21,355	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,252		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAY CARE MANAGEMENT, LTD.
Street Address: 7313 N. WESTERN AVE.
City / State / Zip Code: CHICAGO, IL. 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	177,354	5	$ 8,146	$	31,154	$ 1,431	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	177,354	5	3,250		31,154	571	2
3	10	REHABILITATION CONS.	PATIENT DAYS	177,354	5	(3,636)		31,154	(639)	3
4	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	177,354	5	82,960	82,960	31,154	14,573	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	177,354	5	5,905		31,154	1,037	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	177,354	5	1,497		31,154	263	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	177,354	5	136,787	96,823	31,154	24,028	7
8	24	SEMINARS	PATIENT DAYS	177,354	5	1,675		31,154	294	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	177,354	5	8,245		31,154	1,448	9
10	26	INSURANCE	PATIENT DAYS	177,354	5	7,905		31,154	1,389	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	177,354	5	24,552		31,154	4,313	11
12	30	DEPRECIATION	PATIENT DAYS	177,354	5	11,266		31,154	1,979	12
13	34	BUILDING RENT	PATIENT DAYS	177,354	5	42,960		31,154	7,546	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	177,354	5	20,136		31,154	3,537	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 351,648	$ 179,783		$ 61,770	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: STAY CARE MANAGEMENT, LTD.
Street Address: 7313 N. WESTERN AVE.
City / State / Zip Code: CHICAGO, IL. 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	19,277	19,277			1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	8	5,262	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,603				3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	5,291		8	1,058	4
5	17	ADMIN. BONUS	AVG. HOURS WORKED	40	1	250				5
6	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	277,610	277,610	5	21,355	6
7	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	263,887	263,887	15	60,897	7
8	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	13,264		5	1,020	8
9	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	13,052		15	3,012	9
10	30	DEPR.- AUTO - MINI VAN	AVG. HOURS WORKED	35	1	1,775				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 622,319	$ 587,084		$ 92,604	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Arbour HHC Ltd. Partnership	X		Mortgage		1996	$	$ 1,947,692			$ 174,588	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,947,692			$ 174,588	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	Interest Income										(8,715)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,715)	14
15	TOTALS (line 9+line14)						$	$ 1,947,692			$ 165,873	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	126,268	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	119,449	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,819)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	125,421	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	118,602	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	111,608	8
1996	114,354	9
1997	118,158	10
1998	120,256	11
1999	119,449	12

2000 Tax Accrual - $119,449 X 5% = $125,421

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1996	$ 118,000	1
2					2
3	TOTALS			$ 118,000	3

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1996		$ 1,995,443	$ 51,165	20	$ 99,772	$ 48,607	$ 448,974	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	7,848		20	392	392	4,487	9
10	Various			1990	41,826	940	20	2,227	1,287	23,566	10
11	Various			1992	21,600	686	20	1,080	394	8,820	11
12	Various			1993	5,318	71	20	266	195	2,088	12
13	Various			1995	21,420	440	20	1,070	630	5,925	13
14	NEW ROOF			1996	16,100	413	20	805	392	3,623	14
15	TUCKPOINTING & BRICK			1997	4,950		20	248	248	806	15
16	SPRINKLER HEADS			1997	848		20	42	42	158	16
17	TELEPHONE WIRING			1997	731		20	37	37	120	17
18	EJECTOR PUMP BEARING			1997	725		20	36	36	120	18
19	SINK & FAUCETS			1997	767		20	38	38	133	19
20	PLUMBING			1997	2,775		20	139	139	452	20
21	114 WINDOWS			1997	41,000	1,051	20	2,050	999	6,833	21
22	EJECTOR PUMP			1997	1,637		20	82	82	301	22
23	DOORS			1998	1,280		20	64	64	139	23
24											24
25	PAGE 12-1 REP TOTALS				4,977	1,979		161	(1,818)	1,361	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				27,945			1,397	1,397	2,358	35
36	TOTAL (lines 4 thru 35)				$ 2,197,190	$ 56,745		$ 109,906	$ 53,161	$ 510,264	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COX-CONSULTING			1998	2,418		20	121	121	303	9
10	WALLPAPER			1998	1,445		20	72	72	168	10
11	COX-CONSULTING			1998	2,624		20	131	131	349	11
12	COX-CONSULTING			1998	1,100		20	55	55	133	12
13	COX-CONSULTING			1998	913		20	46	46	107	13
14	COX-CONSULTING			1998	584		20	29	29	60	14
15	PAINT & WALLPAPER			1998	1,780		20	89	89	200	15
16	DAMPERS			1998	1,640		20	82	82	178	16
17	DAMPERS & DOORS			1998	1,316		20	66	66	154	17
18	BOOSTER			2000	801		20	40	40	40	18
19	PLUMBING			2000	648		20	32	32	32	19
20	PLUMBING			2000	760		20	38	38	38	20
21	SRINKLER			2000	863		20	43	43	43	21
22	EJECTOR PUMP			2000	2,275		20	114	114	114	22
23	EJECTOR PUMP			2000	2,275		20	114	114	114	23
24	IRON			2000	2,241		20	112	112	112	24
25	LIGHTING			2000	3,500		20	175	175	175	25
26	TILE			2000	762		20	38	38	38	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 27,945	$		$ 1,397	$ 1,397	$ 2,358	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
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17											17
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23											23
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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15											15
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Staycare			1992	3,067	69	20	153	84	1,353	9
10	Allocation from Staycare			2000	1,910	1,910	20	8	(1,902)	8	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,977	$ 1,979		$ 161	$ (1,818)	$ 1,361	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 289,985	$ 22,089	$ 28,997	$ 6,908		$ 136,184	37
38	Current Year Purchases	4,447		444	444		444	38
39	Fully Depreciated Assets	9,845		199	199		9,845	39
40								40
41	TOTALS	$ 304,277	$ 22,089	$ 29,640	$ 7,551		$ 146,473	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,619,467	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 78,834	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 139,546	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 60,712	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 656,737	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ARBOUR HEALTH CARE CENTER
0034736
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Arbour Health Care Center	30,731		3,071	3,071	17,327
Arbour Health Care Center Limited Partnership	247,500	22,089	24,750	2,661	111,375
Stay Care Management	11,754		1,176	1,176	7,482
TOTALS	289,985	22,089	28,997	6,908	136,184
LINE 29: CURRENT YEAR					
Arbour Health Care Center	4,447		444	444	444
Arbour Health Care Center Limited Partnership					
Stay Care Management					
TOTALS	4,447		444	444	444
LINE 30: FULLY DEPRECIATED					
Arbour Health Care Center	9,845		199	199	9,845
Arbour Health Care Center Limited Partnership					
Stay Care Management					
TOTALS	9,845		199	199	9,845
TOTALS (Should Tie to Totals on Page 13)					
Arbour Health Care Center	45,023		3,714	3,714	27,616
Arbour Health Care Center Limited Partnership	247,500	22,089	24,750	2,661	111,375
Stay Care Management	11,754		1,176	1,176	7,482
TOTALS	304,277	22,089	29,640	7,551	146,473

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Stay Care			7,546			5
6								6
7	TOTAL				$ 7,546 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,771 Description: TV lease $2234; Allocation from Staycare: $3537
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 268,438	$ 268,438	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	619,960	619,960	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,474	47,474	6
7	Other Prepaid Expenses	375	375	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 936,247	$ 936,247	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		118,000	13
14	Buildings, at Historical Cost		1,995,443	14
15	Leasehold Improvements, at Historical Cost	128,268	128,268	15
16	Equipment, at Historical Cost	43,318	290,818	16
17	Accumulated Depreciation (book methods)	(66,872)	(487,261)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 104,714	$ 2,045,268	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,040,961	$ 2,981,515	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,370	$ 65,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,050	48,050	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,542	3,542	31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,421	125,421	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	15,655	15,655	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	24,173	24,173	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 282,211	$ 282,211	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,947,692	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,947,692	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 282,211	$ 2,229,903	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 758,750	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,040,961	$ #REF!	48

*(See instructions.)

Facility Name & ID Number ARBOUR HEALTH CARE CENTER **#** 0034736 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Exchange	8,711	8,711
Due to IDPA	15,462	15,462
	24,173	24,173

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 610,443	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 610,443	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	247,307	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(99,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 148,307	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 758,750	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	ARBOUR HEALTH CARE CENTER #	0034736	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		610,443
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		610,443
Equity(Deficit) from Page 17 Col 1		758,750
Related Party		
Equity(Deficit)	-41498	
Income	34359	
		(7,139)
Combined Equity - End of Year		751,611

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,048,515	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,048,515	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,715	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,715	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,057,230	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	583,156	31
32	Health Care	1,124,410	32
33	General Administration	641,369	33
	B. Capital Expense		
34	Ownership	406,636	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,809,923	40
41	**Income before Income Taxes (line 30 minus line 40)****	247,307	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 247,307	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ARBOUR HEALTH CARE CENTEF # 0034736 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,141	2,213	$ 62,330	$ 28.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,498	15,499	309,900	19.99	3
4	Licensed Practical Nurses	10,412	11,629	203,468	17.50	4
5	Nurse Aides & Orderlies	36,584	41,395	321,882	7.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,747	5,436	40,297	7.41	8
9	Activity Director	1,813	2,126	20,250	9.52	9
10	Activity Assistants	6,224	6,607	39,197	5.93	10
11	Social Service Workers	3,993	5,593	59,142	10.57	11
12	Dietician					12
13	Food Service Supervisor	1,619	1,723	24,239	14.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,180	14,624	96,469	6.60	15
16	Dishwashers					16
17	Maintenance Workers	2,417	2,805	26,643	9.50	17
18	Housekeepers	12,986	14,048	87,454	6.23	18
19	Laundry	5,910	6,369	37,383	5.87	19
20	Administrator	1,898	2,166	60,199	27.79	20
21	Assistant Administrator	2,136	2,439	62,128	25.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,901	6,075	39,770	6.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,391	1,549	19,341	12.49	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	127,850	142,296	$ 1,510,092 *	$ 10.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,931	1-3	35
36	Medical Director	Monthly	1,800	9-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,428	10-3	39
40	Physical Therapy Consultant	76	4,012	10a-3	40
41	Occupational Therapy Consultant	204	10,582	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	132	10a-3	43
44	Activity Consultant	58	3,090	11-3	44
45	Social Service Consultant	81	4,318	12-3	45
46	Other(specify)				46
47	Psycho-Social Consultant	25	1,284	12-3	47
48					48
49	TOTAL (lines 35 - 48)	448	$ 36,609		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Faila	Adminstrator	0	$ 60,199
Brecilda Rodriquez (1/1 - 10/15/00)	Asst. Admin.	0	51,426
Nicky Vujahovic (10/16 - 12/31/00)	Asst. Admin.	0	10,702
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 122,327

B. Administrative - Other

Description	Amount
Staycare - Management Fees	$ 173,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 173,000

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 13,785
Sachnoff & Weaver	Legal	970
Personnel Planners	Unemployment Consultant	963
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 15,718

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,338
Unemployment Compensation Insurance	11,247
FICA Taxes	114,845
Employee Health Insurance	36,590
Employee Meals	26,132
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,188
Employment Retirement Fund	400
Employee Benefits	36
Union Pension Expense	9,004
Christmas Expense	700
401K	3,739
TOTAL (agree to Schedule V, line 22, col.8)	$ 220,219

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	450
(Indicate # of checks performed 45)	
Classified Advertising	5,382
Dues & Subscriptions	4,164
License, Permits & Fees	2,726
Allocation from Staycare	263
Yellow Page Advertising	1,974
Nurse Employee Recruitment	8,550
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,974)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,735

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,058
Allocation from Staycare	294
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,352

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Plumbing Repairs	5/94	$ 2,074	3	$ 346	$ 0	$ 0	$ 0	$	$	$	$	$
2	Heating & A/C Repairs	6/94	1,874	3	312	0	0	0					
3	Plumbing Repairs	12/94	1,880	3	574	0	0	0					
4	Wallpapering	6/94	1,605	3	267	0	0	0					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,433		$ 1,499	$	$	$	$	$	$	$	$

Facility Name & ID Number ARBOUR HEALTH CARE CENTER # 0034736 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $4163**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,127** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,351**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,132** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When

paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw